of these symptoms will be absent, especially those indicating partial or complete escape into the abdomen. Indeed, the rupture may not be discovered until the child is born, or may never be suspected, unless septic peritonitis after labor should suddenly set in.

Prognosis—This will depend upon the site, the degree and the extent of the rent, and upon its treatment. Incomplete ruptures are not so fatal as those in which the peritonem is also involved. The result will depend much upon whether or not there was escape of mecomium, liquor amnii, blood, placenta or foetus into the abdominal cavity.

Before the advent of asepsis the mortality was over 90%; since then it has been largely reduced. The survival of the child is a rare exception.

Management—The prophylactic treatment includes all that is required of a careful and well trained, observing obestrician. Such a calamity may, in a large majority of cases, be avoided by a careful diagnosis of the existing conditions before labor commences, or during the progress of its initial stages, and measures taken to combat them.

A careful employment of anæsthetics in cases where there is a tendency to tetanic contraction may avert much trouble. In minor degrees of pelvic contractions, a careful watch must be kept over the uterine contractions, and the rise of the ring of Bandl. The fundamental principle in all cases of threatened rupture is early termination of labor by the method most conducive to material safety, whether by forceps, version, or craniotomy, or by whatever method the circumstances of the case requires or will admit. Extra care must be taken to avoid violence in manipulation, particularly if version is attempted. The lower uterine segment may be ruptured even by moderate manipulation.

When the child is dead, or rupture imminent, or impacted shoulder, craniotomy or embryotomy should be resorted to by preference.

Once rupture has occurred, it is difficult, owing to the exigencies of the case, to dictate a plan of treatment.